

<i>SERFF Tracking Number:</i>	<i>AEGX-126459072</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Stonebridge Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>44612</i>
<i>Company Tracking Number:</i>	<i>HA AR0053315F01</i>		
<i>TOI:</i>	<i>H03G Group Health - Accidental Death &amp; Dismemberment</i>	<i>Sub-TOI:</i>	<i>H03G.000 Health - Accidental Death &amp; Dismemberment</i>
<i>Product Name:</i>	<i>Accidental Death</i>		
<i>Project Name/Number:</i>	<i>Accidental Death/HA AR0053315F01</i>		

## Filing at a Glance

Company: Stonebridge Life Insurance Company

Product Name: Accidental Death

SERFF Tr Num: AEGX-126459072 State: Arkansas

TOI: H03G Group Health - Accidental Death & Dismemberment

SERFF Status: Closed-Approved- Closed State Tr Num: 44612

Sub-TOI: H03G.000 Health - Accidental Death & Dismemberment

Co Tr Num: HA AR0053315F01 State Status: Approved-Closed

Filing Type: Form

Author: SPI ADMSLH

Reviewer(s): Rosalind Minor

Date Submitted: 01/15/2010

Disposition Date: 01/22/2010

Disposition Status: Approved-Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

## General Information

Project Name: Accidental Death

Status of Filing in Domicile: Not Filed

Project Number: HA AR0053315F01

Date Approved in Domicile:

Requested Filing Mode: Informational

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Overall Rate Impact:

Group Market Type: Discretionary

Filing Status Changed: 01/22/2010

Explanation for Other Group Market Type:

State Status Changed: 01/22/2010

Deemer Date:

Created By: SPI ADMSLH

Submitted By: SPI ADMSLH

Corresponding Filing Tracking Number:

Filing Description:

We are filing for your review and acknowledgement new forms. These forms do not replace any forms previously acknowledged by your Department. These forms have been completed in "John Doe" fashion.

SLAD3700GC is a Group Accidental Death Insurance Certificate which provides an Accidental Death Benefit if an Insured suffers a Loss in an accident while riding as a fare paying passenger inside a common carrier or as a result of a collision or crash of a motor vehicle. Coverage ends when the Insured attains age 80.

<i>SERFF Tracking Number:</i>	<i>AEGX-126459072</i>	<i>State:</i>	<i>Arkansas</i>
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SLAD3700GP is the Master Policy under which SLAD3700GC Certificates will be issued. We plan to issue the Master Policy to various discretionary groups that are situated in Missouri. These forms were approved by Missouri, our Situs State, on November 18, 2009.

Enrollment Form SLAD3700GE will be used to solicit this and other similar products. This Enrollment Form will have the fraud warning notice on the back or on the front.

The Flesch scores for SLAD3700GP and SLAD3700GC are 44.1 and 49.0 respectively. Microsoft Word was used to obtain these scores.

All variable information is bracketed and printed in red. We request acknowledgement of these forms with various dimensions, format, shading and colors. No dimension, format, shading or color change will produce unacceptable print.

This product is guaranteed renewable and will be mass marketed by direct response, kiosk and telemarketing methods and possibly on the Internet through our website.

We ask that this filing become effective upon the date of your acknowledgement.

## Company and Contact

### Filing Contact Information

Deborah Yates, Product Filing & Compliance Analyst	dyates@aegonusa.com
520 Park Avenue	410-209-5269 [Phone]
Baltimore, MD 21201	410-209-5910 [FAX]

### Filing Company Information

Stonebridge Life Insurance Company	CoCode: 65021	State of Domicile: Vermont
29 South Main Street	Group Code: 468	Company Type: Life and Health
Rutland, VT 05701-5014	Group Name:	State ID Number:
(410) 685-5500 ext. [Phone]	FEIN Number: 03-0164230	

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## Filing Fees

Fee Required?	Yes
Fee Amount:	\$50.00

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Stonebridge Life Insurance Company	\$50.00	01/15/2010	33577558

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## Correspondence Summary

### Dispositions

<b>Status</b>	<b>Created By</b>	<b>Created On</b>	<b>Date Submitted</b>
Approved-Closed	Rosalind Minor	01/22/2010	01/22/2010

<i>SERFF Tracking Number:</i>	<i>AEGX-126459072</i>	<i>State:</i>	<i>Arkansas</i>
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<i>Product Name:</i>	<i>Accidental Death</i>		
<i>Project Name/Number:</i>	<i>Accidental Death/HA AR0053315F01</i>		

## Disposition

Disposition Date: 01/22/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

<i>SERFF Tracking Number:</i>	<i>AEGX-126459072</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Stonebridge Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>44612</i>
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<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	AR - NAIC TRANSMITTAL DOCUMENT	Approved-Closed	Yes
<b>Supporting Document</b>	AR - NAIC FORM FILING ATTACHMENT	Approved-Closed	Yes
<b>Supporting Document</b>	Cover Letter	Approved-Closed	Yes
<b>Supporting Document</b>	Explanation of Variables	Approved-Closed	Yes
<b>Form</b>	Group Accident Insurance Policy	Approved-Closed	Yes
<b>Form</b>	Group Accident Insurance Certificate of Insurance	Approved-Closed	Yes
<b>Form</b>	Enrollment Form	Approved-Closed	Yes

SERFF Tracking Number: AEGX-126459072 State: Arkansas

Filing Company: Stonebridge Life Insurance Company State Tracking Number: 44612

Company Tracking Number: HA AR0053315F01

TOI: H03G Group Health - Accidental Death & Sub-TOI: H03G.000 Health - Accidental Death & Dismemberment

Product Name: Accidental Death

Project Name/Number: Accidental Death/HA AR0053315F01

## Form Schedule

Lead Form Number: SLAD3700GP

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 01/22/2010	SLAD3700 GP	Policy/Cont ractal	Group Accident Insurance Policy Certificate	Initial		44.100	SLAD3700GP .PDF
Approved-Closed 01/22/2010	SLAD3700 GC	Certificate	Group Accident Insurance Certificate of Insurance	Initial		49.000	SLAD3700GC .PDF
Approved-Closed 01/22/2010	SLAD3700 GE	Application/ Enrollment Form	Enrollment Form	Initial		0.000	SLAD3700GE .PDF

# Stonebridge Life Insurance Company

Home Office: Rutland, Vermont  
Administrative Office: 2700 West Plano Parkway  
Plano, Texas 75075

**Stonebridge Life Insurance Company**  
(Herein called the Company)

Having issued this Policy to

**XYZ CORPORATION**  
(Herein called Policyholder)

Agrees to pay the benefits herein provided with respect to  
persons Insured hereunder, subject to all terms of this Policy.

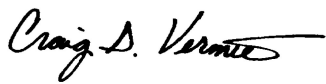
This Policy is issued in consideration of the payment of premium and statements made in the application herein provided, and shall take effect on DECEMBER 1, 2009 which shall be its date of issue. Policy anniversaries shall be YEARLY and each subsequent YEAR.

This Policy is issued in the State of Missouri, and its terms shall be construed in accordance with the laws of the State of Missouri.

## RIGHT TO EXAMINE CERTIFICATE

A person who enrolls for coverage may return the Certificate of Insurance within [30] days after its receipt to the Company at its Administrative Office. If the Certificate is returned, insurance under this Policy shall be deemed void from the Certificate's Effective Date. Any premium paid by the Insured will be refunded. The Certificate will be treated as if it never existed. No benefits will be paid.

The provisions and conditions of this Policy shall form a part of the contract as fully as if recorded in detail above the signatures hereunder affixed.



Secretary



President

Policy No.: **XXXXXXXX**

**GROUP ACCIDENT INSURANCE POLICY  
PROVIDING ACCIDENTAL DEATH BENEFITS TO AGE 80  
GUARANTEED RENEWABLE**



## DEFINITIONS

**INSURED** means the Insured named in the Certificate Schedule of Insurance, and whose coverage has become effective.

**COVERED PERSON** means, for coverage purposes only, the Insured and spouse, provided coverage has become effective.

**INJURY** means bodily harm caused by an accident which occurs while the Certificate is in force. The injury must be the direct cause of Loss, independent of all other causes. Injury must not be caused by or contributed to by disease or bodily infirmity.

**INJURED** means having suffered an Injury.

**LOSS** means loss of life.

**PRIVATE PASSENGER AUTOMOBILE** means a four-wheeled automobile which is required to be registered with the state for non-commercial use on public highways and includes station wagons, vans, jeeps or truck types with a factory rating load capacity of 2,000 pounds or less or self-propelled motor home type vehicles.

Farm equipment, forklifts, construction equipment, all terrain vehicles, golf carts, dune buggies, snowmobiles, go carts, and any and all vehicles designed primarily for off road use and vehicles registered to carry passengers for hire are specifically excluded under Private Passenger Automobile.

**LAND MOTOR VEHICLE** includes any gasoline, diesel, electric or similarly powered vehicle which is required to be registered with the state for use on public highways, customarily used for transportation on land and for which the operator is required to be licensed.

This category includes, but is not limited to the following:

1. vehicles defined as "Private Passenger Automobiles" in this Certificate;
2. vehicles with more than four wheels, such as tractor/trailer rigs and flat bed trucks; and
3. trains.

Farm equipment, forklifts, construction equipment, recreational vehicles, motorcycles, motor scooters, all terrain vehicles, snowmobiles, vehicles designed primarily for off road use and vehicles registered to carry passengers for hire are specifically excluded under Land Motor Vehicle.

**COMMON CARRIER** means a public conveyance which is:

1. licensed to transport passengers for hire by a duly constituted authority having jurisdiction in the state or country in which said conveyance operates; and
2. provided and operated (a) for regular passenger service by land, water, or air, and (b) on a regular passenger route with regularly published schedules of departures and arrivals between established and recognized points of departure and arrival; and
3. provided and operated under a valid license or operating specifications for commercial transportation at the time of Loss.

The following modes of transportation are specifically excluded under Common Carrier:

1. chartered buses, airplanes, helicopters and boats
2. taxis, limousines and shuttle services
3. school buses and vans.

**[PARTICIPATING GROUP** means a group that requests to participate in the Insurance Trust known as the Policyholder and whose participating has been approved by the Company. The name of such group is shown in the Certificate Schedule of Insurance.]

**[AEGON AFFILIATE** includes Stonebridge Casualty Insurance Company, Transamerica Life Insurance Company, Transamerica Financial Life Insurance Company and Monumental Life Insurance Company.]

## ELIGIBILITY

[Each natural person AGE [18] THROUGH [74] WHO IS AN XYZ CORPORATION ACCOUNTHOLDER (OR THE SPOUSE OF AN XYZ CORPORATION ACCOUNTHOLDER AGE [18] THROUGH [74]) is eligible to become an Insured.] Such persons are herein called eligible persons.

[No person shall be covered under more than one Certificate of Insurance under this Policy [with the Participating Group] named in the Certificate Schedule of Insurance. Each Certificate may cover only one Insured. If a person is recorded by the Company as an Insured under more than one certificate, such person shall be deemed to be Insured only under the certificate which affords that person the greatest amount of coverage. Upon discovery of the duplication of coverage, any premium for the duplicate coverage made by, or on behalf of, the Insured will be refunded.]

In no event will a corporation, partnership, or business entity, other than a natural person, be eligible for insurance.

## WHEN A PERSON BECOMES INSURED

Each Insured will be issued a Certificate of Insurance which will indicate the coverage, the Effective Date of coverage, and the persons covered.

Each eligible person shall become insured on the Effective Date shown in the Certificate Schedule of Insurance provided the Company receives the initial premium [before][within 21 days] of the Certificate Effective Date and while the Insured is alive.

## WHEN A PERSON'S INSURANCE ENDS

An Insured's insurance ends on the earlier of:

1. the last day of the period covered by the Insured's last premium contribution; or
2. the Certificate anniversary date following the date the Insured attains age 80.

The Insured may cancel his or her coverage upon notice to the Company. Notice is deemed given when made in writing, communicated verbally by telephone or in person, or by any other means acceptable to the Company. Unless requested otherwise, coverage is cancelled as of the date the cancellation request is made.

In the event the Policy stops, we will give you 31 days notice of this event.

In the event the insurance terminates, it does not affect payment for a Loss which began while the coverage was in force.

## AMOUNTS OF INSURANCE - SCHEDULE OF INSURANCE

When an eligible person enrolls as an Insured under this Policy, he or she will receive coverage as described in the Coverage section of this Policy. The amounts of insurance for each Insured shall be the amount shown in the Certificate Schedule of Insurance issued to each individual Insured.

## COVERAGE

### PART I - BENEFIT FOR TRAVEL BY REGULARLY SCHEDULED COMMON CARRIER

If a Covered Person suffers an Injury causing a Loss as a direct result of a collision, crash or sinking of a duly licensed Common Carrier while riding as a fare paying passenger inside such Common Carrier. The Company will pay the Accidental Death Benefit shown in Part I on the Certificate Schedule of Insurance. The Loss must occur within 90 days after the date of an accident which caused such Injury.

## **PART II - BENEFIT FOR TRAVEL BY PRIVATE PASSENGER AUTOMOBILE AND LAND MOTOR VEHICLE**

If a Covered Person suffers an Injury causing a Loss:

1. by being struck by a Private Passenger Automobile or Land Motor Vehicle, or
2. as a direct result of a collision or crash of a Private Passenger Automobile or Land Motor Vehicle

the Company will pay the Accidental Death Benefit shown in Part II on the Certificate Schedule of Insurance. The Loss must occur within 90 days after the date of an accident which caused such Injury.

### **EXCLUSIONS**

No benefit shall be paid for Loss or Injury that is caused by, results from or contributed to by:

1. an intentionally self-inflicted Injury, suicide, or any attempt at suicide, while sane;
2. any active participation in a riot, insurrection or war, either declared or undeclared;
3. the Covered Person's taking or using any narcotic, barbiturate or any other drug or medication, unless taken or used as prescribed by a Physician;
4. the Covered Person's blood alcohol level being .08 percent weight by volume or higher;
5. the Covered Person operating or riding in any kind of aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight;
6. the Covered Person committing or attempting to commit a felony or an assault or being engaged in an illegal activity;
7. sickness, bodily or mental infirmity or their medical or surgical treatment including diagnosis (except bacterial infections which result from an Injury) or mental disease or disorder;
8. voluntary gas inhalation or poison voluntarily taken, administered or inhaled;
9. taking alcohol in combination with any drug, medication or sedative;
10. military or combat activities while serving in the armed forces, National Guard or organized reserve corps in any state, country or international authority; or
11. a natural disaster such as an earthquake.

### **RENEWAL CONDITIONS**

Prior to the expiration of the Grace Period of the Insured's Certificate, the payment of the renewal premium is required to keep the Certificate in effect.

An Insured may keep the Certificate in force until he reaches age 80. The Company does not have the right to:

1. cancel the Insured's coverage; or
2. place any restriction on the Insured's coverage while it is in force; or
3. refuse a premium paid on or before the date due or within the Grace Period.

All renewal premiums will be based on the Company's rates in effect for this Policy on the date such premiums are due. The Company does have the right to change the table of rates from time to time. The new rates will be based on the ages of the Covered Persons on the dates they became insured.

The Company will not increase the Insureds' rates in the first Certificate year of coverage. After that, rates will not increase more than once in any 12 month period. There will be no change in the class of the Covered Persons due to any physical impairment or claim incurred.

If a person is added to or removed from coverage, the premium amount may be adjusted to reflect the change in coverage. Renewal premiums are due on the first day of each renewal period. An Insured's coverage will expire if the premium is not paid by the end of the Grace Period.

### **PREMIUM**

Premium for the Insured is included on the attached rate sheet.

### **BENEFICIARY**

All benefits are payable to the Insured, if living. Unless the Insured specifies otherwise, any other benefit due for Loss of life will be paid as follows:

1. at the Insured's death, it will be paid to his living lawful spouse; or if he does not have one,
2. in equal shares to the Insured's living lawful children; or if there are none,
3. in equal shares to the Insured's living lawful parents; or if there are none,
4. in equal shares to the Insured's living lawful brothers and sisters; or if there are none,
5. to the Insured's estate.

Spouse means only the one to whom the Insured is lawfully married on the date of his death. Except in the case of a legal adoption, lawful children, parents, brothers and sisters do not mean "step" children, parents, brothers or sisters.

## **CONTINUATION OF COVERAGE**

In the event of the Insured's death, his covered spouse, if any, shall be deemed the Insured provided the spouse has not reached age 80. Otherwise, the coverage will terminate on the next monthly renewal date. If the Insured's spouse ceases to be his spouse for reasons other than his death, the Insured's spouse will no longer be covered as of the next monthly renewal date.

## **CONVERSION**

The covered spouse whose coverage ceases may apply for his or her own certificate within 31 days after coverage ceases. No evidence of insurability will be required. The new certificate will be issued:

1. on the Company's form at that time with benefits most like but not greater than those of the Insured's Certificate; and
2. at the adult rate for the attained age of the person at that time.

The effective date of coverage under the new certificate will be the same as the effective date of the conversion. The Company will not pay under the new certificate for any Loss for which benefits have been paid under the Insured's Certificate.

## **GENERAL PROVISIONS**

### **ENTIRE CONTRACT**

The Insured's Certificate is furnished in accordance with and subject to the terms of this Policy. It is not part of the Policy, but it is evidence of the insurance provided under the Policy. The Policy and any attachments form the entire contract of insurance. No agent may change or waive any provisions of the Policy under which this coverage is provided.

### **INCONTESTABILITY**

The Company cannot contest the Certificate except for fraud or for not paying premiums.

### **INFORMATION TO BE FURNISHED**

The [Policyholder][Participating Group] shall furnish the Company with any information required to administer this Policy. The Company shall have the right to inspect any record of the [Policyholder][Participating Group] or in possession of the [Policyholder][Participating Group] which relates to this Policy.

## **CLERICAL ERROR**

A clerical error in the records relative to this insurance shall not invalidate insurance or cause insurance to be in force or to continue in force. Upon discovery of such error, an equitable adjustment shall be made in the premium.

## **INSURED'S CERTIFICATE**

The Company will issue an individual Certificate to each Insured. The Certificate will describe the insurance coverage and state to whom the benefits will be paid.

## **CHANGE OF BENEFICIARY**

The Insured may change the Beneficiary at any time by writing to the Company at its Administrative Office. Once the change is recorded by the Company, it will take effect as of the day the Insured signed the request, subject to any claim payment made before such recording. The consent of the beneficiary is not needed for the change, unless the beneficiary designation was irrevocable. Any change of Beneficiary is subject to community property laws in the Insured's state of residence.

## **PAYMENT OF PREMIUM**

All premiums due by the terms of this Policy shall be paid to the Administrative Office of the Company on or prior to the day they are due.

[For the first [30] days of coverage, the premium will be paid by the [Policyholder/Participating Group.]]

[After the first [30] days,] the Insured is required to contribute 100 percent of the premium payable for the Certificate.

The Company has the right to change the table of rates on any premium due date after an Insured's Certificate has been in force one year. The Company will provide written notice to the [Participating Group][Policyholder] at least 31 days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed but not more than once in a twelve month period.

## **GRACE PERIOD**

If a premium is not paid when due, the insurance shall be in default. The Company will allow a 31-day grace period to pay each premium after the first one. If a premium is not paid on or before the end of the grace period, the insurance shall terminate effective the last day of the period covered by the last premium contribution. No benefits are paid for a Loss occurring after the expiration of the grace period.

## **REINSTATEMENT**

The Insured's Certificate will lapse if the Insured does not pay his or her premium before the end of the Grace Period. If the Company later accepts a premium and does not require an application for reinstatement, that payment will put the Certificate back in force. If the Company requires an application for reinstatement, the Certificate will be put back in force when the Company approves it, and the required premium is received. If the Company does not approve it, the Certificate will be put back in force on the 45<sup>th</sup> day after the date of application for reinstatement, unless the Company gives the Insured prior written notice of its disapproval.

The reinstated Certificate only covers Loss due to an Injury that occurs after the date of reinstatement. In all other respects, the Company and the Insured have the same rights under the Certificate as were in effect before it lapsed, unless special conditions are added in connection with the reinstatement.

## **NOTICE OF CLAIM**

Written notice of claim must be given to the Company within 30 days after any Loss covered under this Policy occurs or as soon as possible thereafter. The notice should include the Insured's name and Certificate Number as shown in the Certificate Schedule of Insurance. Notice should be mailed to the Company's Administrative Office.

## **CLAIM FORMS**

When the Company receives the Notice of Claim, the Company will send the claimant forms for filing Proof of Loss. If the Company does not send the forms within 15 days, the claimant can meet the Proof of Loss requirement by providing the Company with a written statement describing what happened. The Company must receive this statement within the time given for filing Proof of Loss.

## **PROOF OF LOSS**

Written proof of loss must be given to the Company within 90 days after the date of the Loss or as soon as possible thereafter. Proof must, however, be furnished no later than one year from the time it is otherwise required, except in the absence of legal capacity.

## **MISSTATEMENT OF AGE**

If the Insured's age has been misstated, all amounts payable shall be in the amount the premium paid would have bought for the correct age. If, as a result of misstatement, the Company accepts a premium for any period when coverage would not normally have been in effect, then the Company's liability for such period shall be a refund, upon request, of all premiums paid for such period.

## **TIME OF PAYMENT OF CLAIMS**

The Company will pay all benefits covered by this Policy as soon as the Company receives proper written Proof of Loss sufficient to determine liability.

## **PAYMENT OF CLAIMS**

Loss of life benefits for a Covered Person are payable in accordance with the Beneficiary designation in effect at the time of payment.

## **AUTOPSY**

The Company, at its own expense, may have an autopsy done where it is not forbidden by law.

## **LEGAL ACTIONS**

No action can be brought to recover on this Policy for at least 60 days after written Proof of Loss has been furnished. No such action shall be brought more than 3 years after the date Proof of Loss is required.

## **[OTHER INSURANCE**

If a Covered Person is insured under more than one accidental death policy or certificate in effect with the Company or any Aegon Affiliate at any one time, the Company's maximum liability is limited to the lesser of the total amount of benefits payable under all such policies and certificates or [\$1,000,000]. Upon discovery of duplication in excess of the Company's maximum liability, the Company will refund all premiums paid for all such policies or certificates. The excess will be voided and all premiums paid for such excess shall be returned to the Insured or to the Insured's beneficiary.]

# STONEBRIDGE LIFE INSURANCE COMPANY

A Stock Company

Home Office: Rutland, Vermont

Administrative Office: [2700 West Plano Parkway, Plano, Texas 75075]

## CERTIFICATE OF INSURANCE

Person(s) insured and benefits are shown in the Schedule of Insurance.

Stonebridge Life Insurance Company (herein called "we," "us" or "our") has issued Policy No. [XXXXXXXX] to [XYZ CORPORATION] (herein called Policyholder) which makes available accidental death

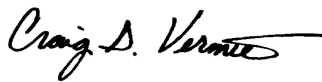
We agree to pay the benefits herein provided with respect to the person(s) insured hereunder, subject to all terms of the Policy.

### RIGHT TO EXAMINE CERTIFICATE

If you are not satisfied with this insurance, you may void it by returning this Certificate within [30] days after you receive it to our Administrative Office. You will receive a full refund of any premium you have paid. This Certificate will be treated as if it never existed. No benefits will be paid.

[This Certificate supersedes any Certificate previously issued to you under the [Policy][Participating Group]. You and any Covered Person may qualify under one Certificate only. If any person is insured under more than one certificate, we will consider that person to be insured under the certificate which provides the greatest amount of coverage. Upon discovery of the duplication, we will refund any duplicated payments which may have been made on behalf of that person.]

The records maintained by the [Policyholder] [Participating Group] shall determine the insurance provided under the Policy for any Insured. Important provisions of the Policy are outlined herein.



Secretary



President

### INSURED:

[JOHN DOE  
221 ANYSTREET  
APARTMENT #1231  
ANYTOWN, USA 12345]

### CERTIFICATE NUMBER:

[82A1000000]

**GROUP ACCIDENT INSURANCE  
PROVIDING ACCIDENTAL DEATH BENEFITS TO AGE 80  
GUARANTEED RENEWABLE**



# STONEBRIDGE LIFE INSURANCE COMPANY

## SCHEDULE OF INSURANCE

This Schedule of Insurance is part of the Certificate. It supersedes any Schedule of Insurance bearing an earlier Effective Date issued under Policy No. XXXXXX to XYZ CORPORATION

[PARTICIPATING GROUP NUMBER: XXXXXX]

PARTICIPATING GROUP: XXXXXXXXX]

[CERTIFICATE NUMBER: 82A1000000  
2010]

EFFECTIVE DATE: 6-01-

[INSURED: JOHN DOE  
221 ANYSTREET  
APARTMENT 1231  
ANYTOWN, USA 12345]

[MONTHLY PREMIUM: \$9.16]

[PREMIUM CONTRIBUTION: 100% AFTER THE FIRST MONTH]

[SPOUSE COVERAGE: YES]

### ACCIDENTAL DEATH INSURANCE SCHEDULE OF INSURANCE

BENEFIT :	AMOUNT	
	<u>INSURED</u>	<u>SPOUSE</u>
[PART I TRAVEL BY REGULARLY SCHEDULED COMMON CARRIER]	[\$100,000]	[\$ 100,000]
[PART II TRAVEL BY PRIVATE PASSENGER AUTOMOBILE AND LAND MOTOR VEHICLE]	[\$ 100,000]	[\$ 100,00]

[COVERAGE TERMINATES AT THE INSURED'S AGE 80.]

## DEFINITIONS

**INSURED** (herein called "you," "your," or "yours") means you, the insured named in the Schedule of Insurance, provided coverage has become effective.

**COVERED PERSON** means, for coverage purposes only, you and your spouse, provided coverage has become effective.

**INJURY** means bodily harm caused by an accident which occurs while this Certificate is in force. The Injury must be the direct cause of Loss, independent of all other causes. Injury must not be caused by or contributed to by disease or bodily infirmity.

**INJURED** means having suffered an Injury.

**LOSS** means loss of life.

**PRIVATE PASSENGER AUTOMOBILE** means a four-wheeled vehicle which is required to be registered with the state for non-commercial use on public highways and includes station wagons, vans, jeeps or truck types with a factory rating load capacity of 2,000 pounds or less.

Farm equipment, forklifts, construction equipment, recreational vehicles, motorcycles, motor scooters, all terrain vehicles, snowmobiles, vehicles designed primarily for off road use and vehicles registered to carry passengers for hire are specifically excluded under Private Passenger Automobile.

**LAND MOTOR VEHICLE** includes any gasoline, diesel, electric or similarly powered vehicle which is required to be registered with the state for use on public highways, customarily used for transportation on land and for which the operator is required to be licensed.

This category includes, but is not limited to the following:

1. vehicles defined as "Private Passenger Automobiles" in this Certificate;
2. vehicles with more than four wheels, such as tractor/trailer rigs and flat bed trucks; and
3. trains.

Farm equipment, forklifts, construction equipment, recreational vehicles, motorcycles, motor scooters, all terrain vehicles, snowmobiles, vehicles designed primarily for off road use and vehicles registered to carry passengers for hire are specifically excluded under Land Motor Vehicle.

**COMMON CARRIER** means a public conveyance which is:

1. licensed to transport passengers for hire by a duly constituted authority having jurisdiction in the state or country in which said conveyance operates; and
2. provided and operated (a) for regular passenger service by land, water, or air, and (b) on a regular passenger route with regularly

published schedules of departures and arrivals between established and recognized points of departure and arrival; and

3. provided and operated under a valid license or operating specifications for commercial transportation at the time of Loss.

The following modes of transportation are specifically excluded under Common Carrier:

1. chartered buses, airplanes, helicopters and boats
2. taxis, limousines and shuttle services
3. school buses and vans.

**[PARTICIPATING GROUP]** means a group that requests to participate in the Insurance Trust known as the Policyholder and whose participating has been approved by us. The name of such group is shown in the Schedule of Insurance.]

**[AEGON AFFILIATE]** includes Stonebridge Casualty Insurance Company, Transamerica Life Insurance Company, Transamerica Financial Life Insurance Company and Monumental Life Insurance Company.]

## WHEN YOUR INSURANCE BEGINS

Issuance of a Certificate is not a waiver of any of the following conditions:

Each eligible person will become insured under this Certificate at 12:01 a.m., Standard Time on the Certificate Effective Date following acceptance by us of the enrollment form, if required, and upon receipt of the first premium [before][within 21 days of] the Certificate Effective Date. The premium and the Effective Date of Coverage is shown on the Certificate Schedule of Insurance.

## WHEN YOUR INSURANCE ENDS

Your insurance ends on the earlier of:

1. the last day of the period covered by your last premium contribution; or
2. the Certificate anniversary date on or after your 80<sup>th</sup> birthday.

You may cancel your coverage upon notice to us. Notice is deemed given when made in writing, communicated verbally by telephone or in person, or by any other means acceptable to us. Unless requested otherwise, coverage is cancelled as of the date the cancellation request is made.

In the event the insurance terminates, it does not affect payment for a Loss which began while the coverage was in force.

## **COVERAGE**

### **PART I - BENEFIT FOR TRAVEL BY REGULARLY SCHEDULED COMMON CARRIER**

If a Covered Person suffers an Injury causing a Loss as a direct result of a collision, crash or sinking of a duly licensed Common Carrier while riding as a fare paying passenger inside such Common Carrier, we will pay the Accidental Death Benefit shown in Part I on the Schedule of Insurance. The Loss must occur within 90 days after the date of an accident which caused such Injury.

### **PART II - BENEFIT FOR TRAVEL BY PRIVATE PASSENGER AUTOMOBILE AND LAND MOTOR VEHICLE**

If a Covered Person suffers an Injury causing a Loss:

1. by being struck by a Private Passenger Automobile or Land Motor Vehicle, or
2. as a direct result of a collision or crash of a Private Passenger Automobile or Land Motor Vehicle

we will pay the Accidental Death Benefit shown in Part II on the Schedule of Insurance. The Loss must occur within 90 days after the date of an accident which caused such Injury.

## **EXCLUSIONS**

No benefit shall be paid for Loss or Injury that is caused by, results from or contributed to by:

1. an intentionally self-inflicted Injury, suicide, or any attempt at suicide, while sane or insane (in Colorado and Missouri, while sane);
2. any active participation in a riot, insurrection or war, either declared or undeclared;
3. the Covered Person's taking or using any narcotic, barbiturate or any other drug or medication, unless taken or used as prescribed by a Physician;
4. the Covered Person's blood alcohol level being .08 percent weight by volume or higher;
5. the Covered Person operating or riding in any kind of aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight;
6. the Covered Person committing or attempting to commit a felony or an assault or being engaged in an illegal activity;
7. sickness, bodily or mental infirmity or their medical or surgical treatment including diagnosis (except bacterial infections which result from an Injury) or mental disease or disorder;
8. voluntary gas inhalation or poison voluntarily taken, administered or inhaled;
9. taking alcohol in combination with any drug, medication or sedative;
10. military or combat activities while serving in the armed forces, National Guard or

- organized reserve corps in any state, country or international authority; or
11. a natural disaster such as an earthquake.

## **RENEWAL CONDITIONS**

You may keep this Certificate in force until you reach age 80. We do not have the right to:

1. cancel your coverage; or
2. place any restriction on your coverage while it is in force; or
3. refuse a premium paid on or before the date due or within the Grace Period.

All renewal premiums will be based on our rates in effect for the Policy on the date such premiums are due. We do have the right to change the table of rates from time to time. The new rates will be based on the ages of the Covered Persons on the dates they became insured.

We will not increase your rates in the first Certificate year of coverage. After that, we will not increase your rates more than once in any 12 month period. There will be no change in the class of the Covered Persons due to any physical impairment or claim incurred.

If a person is added to or removed from coverage, the premium amount may be adjusted to reflect the change in coverage. Renewal premiums are due on the first day of each renewal period. Your coverage will expire if the premium is not paid by the end of the Grace Period.

## **BENEFICIARY**

All benefits are payable to you, if living. Unless you specify otherwise, any other benefit due for Loss of life will be paid as follows:

1. at your death, it will be paid to your living lawful spouse; or if you do not have one,
2. in equal shares to your living lawful children; or if there are none,
3. in equal shares to your living lawful parents; or if there are none,
4. in equal shares to your living lawful brothers and sisters; or if there are none,
5. to your estate.

Spouse means only the one to whom you are lawfully married on the date of your death. Except in the case of a legal adoption, lawful children, parents, brothers and sisters do not mean "step" children, parents, brothers or sisters.

## **CONTINUATION OF COVERAGE**

In the event of your death, your covered spouse, if any, shall be deemed the Insured provided your spouse has not reached age 80. Otherwise, the coverage will terminate on the next monthly renewal date. If your spouse ceases to be your spouse for reasons other than your death, your spouse will no

longer be covered as of the next monthly renewal date.

## CONVERSION

The covered spouse whose coverage ceases may apply for his or her own certificate within 31 days after coverage ceases. No evidence of insurability will be required. The new certificate will be issued:

1. on our form at that time with benefits most like but not greater than those of this Certificate; and
2. at the adult rate for the attained age of the person at that time.

The effective date of coverage under the new certificate will be the same as the effective date of the conversion. We will not pay under the new certificate for any Loss for which benefits have been paid under this Certificate.

## GENERAL PROVISIONS

### ENTIRE CONTRACT

Your Certificate is furnished in accordance with and subject to the terms of the Policy. It is not part of the Policy, but it is evidence of the insurance provided under the Policy. The Policy and any attachments form the entire contract of insurance. No agent may change or waive any provisions of the Policy under which this coverage is provided.

### INCONTESTABILITY

We cannot contest this Certificate except for fraud or for not paying premiums.

### CHANGE OF BENEFICIARY

You may change the beneficiary at any time by writing to us at our Administrative Office. Once we record the change, it will take effect as of the day you signed the request, subject to any claim payment made before such recording. The consent of the beneficiary is not needed for the change, unless the beneficiary designation was irrevocable. Any change of beneficiary is subject to community property laws in your state of residence.

### PAYMENT OF PREMIUM

All premiums due by the terms of the Policy shall be paid to our Administrative Office on or prior to the day they are due.

**[For the first [30] days of coverage, the premium will be paid by the [Policyholder] [Participating Group].]**

**[After the first [30] days,] you are required to contribute 100 percent of the premium payable for this Certificate.**

We have the right to change the table of rates on any premium due date after your Certificate has been in force for one year. We will provide written notice to the **[Participating Group][Policyholder]** at least 31 days before the date of change. The premium rates may also be changed at any time the terms of the Policy are changed but not more than once in a twelve month period.

## GRACE PERIOD

If a premium is not paid when due, the insurance shall be in default. We will allow a 31-day grace period to pay each premium after the first one. If a premium is not paid on or before the end of the grace period, the insurance shall terminate, effective the last day of the period covered by your last premium contribution. No benefits are paid for a Loss occurring after the expiration of the Grace Period.

## REINSTATEMENT

Your Certificate will lapse if you do not pay your premium before the end of the Grace Period. If we later accept a premium and do not require an application for reinstatement, that payment will put the Certificate back in force. If we require an application for reinstatement, this Certificate will be put back in force when we approve it and the required premium is received. If we do not approve it, the Certificate will be put back in force on the 45<sup>th</sup> day after the date of application for reinstatement, unless we give you prior written notice of its disapproval.

The reinstated Certificate only covers Loss due to an Injury that is received after the date of reinstatement. In all other respects, you and we have the same rights under the Certificate as were in effect before it lapsed, unless special conditions are added in connection with the reinstatement.

## NOTICE OF CLAIM

Written notice of claim must be given to us within 30 days after any Loss occurs or as soon as possible thereafter. You may give the notice or may have someone do it for you. The notice should include your name and Certificate Number as shown in the Schedule of Insurance. Notice should be mailed to us at our Administrative Office.

## CLAIM FORMS

When we receive the Notice of Claim, we will send the claimant forms for filing Proof of Loss. If we do not send the forms within 15 days, the claimant can meet the Proof of Loss requirement by providing us with a written statement describing what happened. We must receive this statement within the time given for filing Proof of Loss.

## PROOF OF LOSS

Written proof of loss must be given to us within 90 days after the date of the Loss or as soon as possible thereafter. Proof must, however, be furnished no later than one year from the time it is otherwise required, except in the absence of legal capacity.

## MISSTATEMENT OF AGE

If the age of a Covered Person has been misstated, all amounts payable shall be in the amount the premium paid would have bought for the correct age. If, as a result of misstatement, we accept a premium for any period when coverage would not normally have been in

effect, then our liability for such period shall be a refund, upon request, of all premiums paid for such period.

## **TIME OF PAYMENT OF CLAIMS**

We will pay all benefits covered by the Policy as soon as we receive proper written Proof of Loss sufficient to determine liability.

## **PAYMENT OF CLAIMS**

Benefits for a Covered Person are payable in accordance with the beneficiary designation in effect at the time of payment. Otherwise, benefits are payable according to the terms of the Policy.

## **AUTOPSY**

At our expense, we may have an autopsy done where it is not forbidden by law.

## **LEGAL ACTIONS**

No action can be brought to recover on the Policy for at least 60 days after written Proof of Loss has been furnished. No such action shall be brought more than 3 years after the date Proof of Loss is required.

## **[OTHER INSURANCE**

If a Covered Person is insured under more than one accidental death policy or certificate in effect with us or any Aegon Affiliate at any one time, our maximum liability is limited to the lesser of the total amount of benefits payable under all such policies and certificates or [\$1,000,000]. Upon discovery of duplication in excess of our maximum liability, we will refund all premiums paid for all such policies or certificates. The excess will be voided and all premiums paid for such excess shall be returned to you or to your beneficiary.]

## ENROLLMENT FORM

**Yes!** Please enroll me [and my eligible spouse (if selected)] for this optional Group [Accidental Death] Insurance Plan. [The coverage I want is:]

[[01H ☐ Coverage for me and my spouse at [\$9.16] per month.]

[01G ☐ Coverage for me only at [\$4.58] per month].

[☐ Check here to [activate][select] coverage.....\$100,000]

[I understand that if I send in my enrollment form and do not select an option above, I will be enrolled for coverage for me only.] I understand that in order to enroll for this coverage I must be an [XYZ Corporation accountholder or the spouse of an XYZ Corporation accountholder, age [18] through [74], with an account in good standing and reside in a state in which this product may legally be offered]. [The first month's coverage will be provided at no cost to me.] I also understand that coverage ends when [I][a Covered Person] attain[s] age 80. I may discontinue my coverage at any time. My coverage will become effective on the date stated on my Certificate Schedule Page.

[By signing below, I certify that I understand coverage is limited to the lesser of the total benefits payable under all Accidental Death policies and certificates with this Company, Stonebridge Casualty Insurance Company, Transamerica Life Insurance Company, Transamerica Financial Life Insurance Company and/or Monumental Life Insurance Company or [\$1,000,000].]

[I have read the fraud notice on the back of this enrollment form as it applies to my state of residence.]

Name: [ ] Birth Date [ ]

Mo Day Yr

Email: [ ] [☐ Male] [☐ Female]

Address: [ ]

City: [ ] State [ ] ZIP [ ]

Phone:(Home)[ ] [(Business) ]

[Beneficiary Designation: All benefits will be paid to you if living. Unless you specify below, any amount due for Loss of life will be paid in accordance with the Beneficiary Provision in your Certificate of Insurance.]

[Beneficiary to Be Paid At My Death:

Beneficiary's Relationship to Me:

(First Name) (Middle Initial) (Last Name)

Required Signature [ ]

Date [ ]

Mo Day Yr

[C-82 CN-163]

SLAD3700GE

Stonebridge Life Insurance Company • Home Office: Rutland Vermont  
Administrative Office: [2700 West Plano Parkway, Plano, Texas 75075-8200]

CODE



**[Residents of ARKANSAS, NEW MEXICO, and OHIO:** Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Residents of DISTRICT OF COLUMBIA:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**Residents of FLORIDA:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Residents of KENTUCKY:** Any person who knowingly and with intent to defraud or deceive any insurance company, files a statement or claim containing any false, incomplete, or misleading information is guilty of a felony.

**Residents of LOUISIANA:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Residents of MAINE, TENNESSEE and WASHINGTON:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**Residents of MARYLAND:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Residents of NEW JERSEY:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**Residents of PENNSYLVANIA:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.]

<i>SERFF Tracking Number:</i>	<i>AEGX-126459072</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Stonebridge Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>44612</i>
<i>Company Tracking Number:</i>	<i>HA AR0053315F01</i>		
<i>TOI:</i>	<i>H03G Group Health - Accidental Death &amp; Dismemberment</i>	<i>Sub-TOI:</i>	<i>H03G.000 Health - Accidental Death &amp; Dismemberment</i>
<i>Product Name:</i>	<i>Accidental Death</i>		
<i>Project Name/Number:</i>	<i>Accidental Death/HA AR0053315F01</i>		

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status</b>
		<b>Date:</b>
<b>Satisfied - Item:</b> Flesch Certification	Approved-Closed	01/22/2010
<b>Comments:</b> AR - Readability Certification		
<b>Attachment:</b> AR - READABILITY CERTIFICATION.PDF		

	<b>Item Status:</b>	<b>Status</b>
		<b>Date:</b>
<b>Satisfied - Item:</b> Application	Approved-Closed	01/22/2010
<b>Comments:</b> Attached to Forms Schedule		

	<b>Item Status:</b>	<b>Status</b>
		<b>Date:</b>
<b>Satisfied - Item:</b> AR - NAIC TRANSMITTAL DOCUMENT	Approved-Closed	01/22/2010
<b>Comments:</b> AR - NAIC Transmittal Document		
<b>Attachment:</b> AR - NAIC TRANSMITTAL DOCUMENT.PDF		

	<b>Item Status:</b>	<b>Status</b>
		<b>Date:</b>
<b>Satisfied - Item:</b> AR - NAIC FORM FILING ATTACHMENT	Approved-Closed	01/22/2010
<b>Comments:</b> AR - NAIC Form Filing Attachment		
<b>Attachment:</b> AR - NAIC FORM FILING ATTACHMENT.PDF		

<i>SERFF Tracking Number:</i>	<i>AEGX-126459072</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Stonebridge Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>44612</i>
<i>Company Tracking Number:</i>	<i>HA AR0053315F01</i>		
<i>TOI:</i>	<i>H03G Group Health - Accidental Death &amp; Dismemberment</i>	<i>Sub-TOI:</i>	<i>H03G.000 Health - Accidental Death &amp; Dismemberment</i>
<i>Product Name:</i>	<i>Accidental Death</i>		
<i>Project Name/Number:</i>	<i>Accidental Death/HA AR0053315F01</i>		

		<b>Item Status:</b>	<b>Status</b>
			<b>Date:</b>
<b>Satisfied - Item:</b>	Cover Letter	Approved-Closed	01/22/2010
<b>Comments:</b>			
Cover Letter			
<b>Attachment:</b>			
Cover Letter.PDF			


		<b>Item Status:</b>	<b>Status</b>
			<b>Date:</b>
<b>Satisfied - Item:</b>	Explanation of Variables	Approved-Closed	01/22/2010
<b>Comments:</b>			
Explanation of Variables			
<b>Attachment:</b>			
Explanation of Variables.PDF			

**STATE OF ARKANSAS**  
**READABILITY CERTIFICATION**

**COMPANY NAME:** Stonebridge Life Insurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
SLAD3700GP	44.1
SLAD3700GC	49
SLAD3700GE	0

Signed:   
Name: Cheryl Penner  
Title: Assistant Secretary  
  
Date: January 15, 2010

**Life, Accident & Health, Annuity, Credit Transmittal Document**

<b>1. Prepared for the State of</b>	Arkansas
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<b>2.</b>	<b>Department Use Only</b>
	<b>State Tracking ID</b>

<b>3. Insurer Name &amp; Address</b>	<b>Domicile</b>	<b>Insurer License Type</b>	<b>NAIC Group #</b>	<b>NAIC #</b>	<b>FEIN #</b>	<b>State #</b>
Stonebridge Life Insurance Company 29 South Main Street Rutland VT 05701-5014	VT	Life, Accident and Health	468	65021	03-0164230	

<b>4. Contact Name &amp; Address</b>	<b>Telephone #</b>	<b>Fax #</b>	<b>E-mail Address</b>
Deborah A. Yates 520 Park Avenue Baltimore MD 21201	800-233-4624	410-209-5910	dyates@aegonusa.com

<b>5. Requested Filing Mode</b>	<input type="checkbox"/> Review & Approval <input type="checkbox"/> Combination (please explain): _____ <input type="checkbox"/> Other (please explain): _____	<input type="checkbox"/> File & Use <input checked="" type="checkbox"/> Informational
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<b>6. Company Tracking Number</b>	HA AR0053315F01
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<b>7.</b>	<input checked="" type="checkbox"/> New Submission <input type="checkbox"/> Resubmission	Previous file # _____
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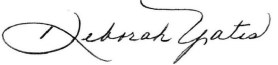
<b>8. Market</b>	<input type="checkbox"/> Individual <input type="checkbox"/> Franchise	<input type="checkbox"/> Small <input type="checkbox"/> Large <input checked="" type="checkbox"/> Small and Large
	Group	<input type="checkbox"/> Employer <input type="checkbox"/> Association <input type="checkbox"/> Blanket <input checked="" type="checkbox"/> Discretionary <input type="checkbox"/> Trust <input type="checkbox"/> Other: _____

<b>9. Type of Insurance</b>	H03G Group Health - Accidental Death & Dismemberment
-----------------------------	--

<b>10. Product Coding Matrix Filing Code</b>	H03G.000 Health - Accidental Death & Dismemberment
--	--

<b>11. Submitted Documents</b>	<input checked="" type="checkbox"/> <b>FORMS</b> <input checked="" type="checkbox"/> Policy <input checked="" type="checkbox"/> Application/Enrollment <input type="checkbox"/> Schedule of Benefits	<input type="checkbox"/> Outline of Coverage <input type="checkbox"/> Rider/Endorsement <input type="checkbox"/> Other: _____	<input checked="" type="checkbox"/> Certificate <input type="checkbox"/> Advertising	
	<input type="checkbox"/> <b>RATES</b> <input type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate			
	<input type="checkbox"/> <b>FILING OTHER THAN FORM OR RATE:</b> Please explain: _____			
	<b>SUPPORTING DOCUMENTATION</b> <input type="checkbox"/> Articles of Incorporation <input type="checkbox"/> Association Bylaws <input checked="" type="checkbox"/> Statement of Variability <input type="checkbox"/> Actuarial Memorandum <input type="checkbox"/> Other: _____			<input type="checkbox"/> Third Party Authorization <input type="checkbox"/> Trust Agreement <input type="checkbox"/> Certifications

<b>12.</b>	<b>Filing Submission Date</b>	January 15, 2010
<b>13.</b>	<b>Filing Fee (If required)</b>	Amount <u>\$50.00</u> Check Date <u>N/A - EFT</u> Retaliatory <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Check Number <u>N/A - EFT</u>
<b>14.</b>	<b>Date of Domiciliary Approval</b>	Not Filed
<b>15.</b>	<b>Filing Description:</b>	
	<p>We are filing for your review and acknowledgement new forms. These forms do not replace any forms previously acknowledged by your Department. These forms have been completed in "John Doe" fashion.</p> <p>SLAD3700GC is a Group Accidental Death Insurance Certificate which provides an Accidental Death Benefit if an Insured suffers a Loss in an accident while riding as a fare paying passenger inside a common carrier or as a result of a collision or crash of a motor vehicle. Coverage ends when the Insured attains age 80.</p> <p>SLAD3700GP is the Master Policy under which SLAD3700GC Certificates will be issued. We plan to issue the Master Policy to various discretionary groups that are situated in Missouri. These forms were approved by Missouri, our Situs State, on November 18, 2009.</p> <p>Enrollment Form SLAD3700GE will be used to solicit this and other similar products. This Enrollment Form will have the fraud warning notice on the back or on the front.</p> <p>The Flesch scores for SLAD3700GP and SLAD3700GC are 44.1 and 49.0 respectively. Microsoft Word was used to obtain these scores.</p> <p>All variable information is bracketed and printed in red. We request acknowledgement of these forms with various dimensions, format, shading and colors. No dimension, format, shading or color change will produce unacceptable print.</p> <p>This product is guaranteed renewable and will be mass marketed by direct response, kiosk and telemarketing methods and possibly on the Internet through our website.</p> <p>We ask that this filing become effective upon the date of your acknowledgement.</p>	

<b>16.</b>	<b>Certification (If required)</b>	
<p><b>I HEREBY CERTIFY</b> that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of <u>Arkansas</u>.</p> <p>Print Name <u>Deborah A. Yates</u> Title <u>Product Filing &amp; Compliance Analyst</u></p> <p>Signature <u></u> Date <u>January 15, 2010</u></p>		

<b>17.</b>	<b>Form Filing Attachment</b>	
<b>This filing transmittal is part of company tracking number</b>		HA AR0053315F01
<b>This filing corresponds to rate filing company tracking number</b>		N/A

	<b>Document Name</b>	<b>Form Number</b>		<b>Replaced Form Number</b>
	<b>Description</b>			<b>Previous State Filing Number</b>
01	Group Accident Insurance Policy	SLAD3700GP	<input checked="" type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	N/A - new
02	Group Accident Insurance Certificate of Insurance	SLAD3700GC	<input checked="" type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	N/A - new
03	Enrollment Form	SLAD3700GE	<input checked="" type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	N/A - new
04			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
05			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
06			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
07			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
08			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
09			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
10			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
11			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	



Administrative Office | 520 Park Avenue | Baltimore | Maryland 21201-4500

January 15, 2010

Honorable Jay Bradford  
Commissioner of Insurance  
Arkansas Insurance Department  
1200 West 3<sup>rd</sup> Street  
Little Rock, Arkansas 72201-1904

Re: Stonebridge Life Insurance Company  
NAIC #: 65021 FEIN: 03-0164230  
SLAD3700GC – Group Motor Vehicle Common Carrier Accidental Death Insurance Certificate  
SLAD3700GP – Group Motor Vehicle Common Carrier Accidental Death Insurance Policy  
SLAD3700GE – Group Enrollment Form

Dear Commissioner:

Attached for your review and acknowledgement are copies of the above captioned forms. These forms are new and do not replace any forms previously acknowledged by your Department. These forms have been completed in "John Doe" fashion.

SLAD3700GC is a Group Accidental Death Insurance Certificate which provides an Accidental Death Benefit if an Insured suffers a Loss in an accident while riding as a fare paying passenger inside a common carrier or as a result of a collision or crash of a motor vehicle. Coverage ends when the Insured attains age 80.

SLAD3700GP is the Master Policy under which SLAD3700GC Certificates will be issued. We plan to issue the Master Policy to various discretionary groups that are situated in Missouri. These forms were approved by Missouri, our Situs State, on November 18, 2009.

Enrollment Form SLAD3700GE will be used to solicit this and other similar products. This Enrollment Form will have the fraud warning notice on the back or on the front.

The Flesch scores for SLAD3700GP and SLAD3700GC are 44.1 and 49.0 respectively. Microsoft Word was used to obtain these scores.

All variable information is bracketed and printed in red. We request acknowledgement of these forms with various dimensions, format, shading and colors. No dimension, format, shading or color change will produce unacceptable print.

This product is guaranteed renewable and will be mass marketed by direct response, kiosk and telemarketing methods and possibly on the Internet through our website.

We ask that this filing become effective upon the date of your acknowledgement.

We respectfully request your favorable review and acknowledgement. Should you have any questions, please contact us.

Sincerely,

A handwritten signature in cursive script that reads "Deborah Yates".

Deborah Yates  
Product Filing & Compliance Specialist  
Product Filing and Compliance Department  
Phone: 410-209-5269  
Toll Free: 800-233-4624, Extension 5265  
Fax 410-209-5910  
Email: dyates@aegonusa.com



## Explanation of Variables

The following is an explanation of the variables indicated in the submitted forms.

### GROUP CERTIFICATE SLAD3700GC

#### PAGE 1

COMPANY ADDRESS: Stonebridge Life Insurance Company has several administrative office locations. This product may be solicited from one of three locations, depending on the market. The address on the forms will be one of the following:

- a) 2700 West Plano Parkway  
Plano, Texas 75075-8200
- b) 520 Park Avenue  
Baltimore, Maryland 21201
- c) Valley Forge, Pennsylvania 19493

Policy number and Policyholder name are specific to each policy.

The Right to Examine period may be 30, 60 or 90 days as determined by the policyholder.

Supersedes language will be used when a policyholder wants to limit coverage for each insured.

The term Participating Group will be used when the policy is issued to a participating group trust.

#### PAGE 2

SCHEDULE PAGE: Personal data on the Schedule of Insurance is variable as it pertains to the Insured and the amount of coverage purchased. Benefits offered are determined by the policyholder.

#### PAGE 3 DEFINITIONS:

**Participating Group** will be included when the policy is issued to a participating group.

**Aegon Affiliates** names the companies included in the affiliates and is used in conjunction with the Other Insurance provision.

WHEN YOUR INSURANCE BEGINS: "before" or "within 21 days of" will be used depending on the issue system used.

#### PAGE 5

PAYMENT OF PREMIUM: the second paragraph and the beginning of the second paragraph will be used when the policyholder is paying the initial premium. The term participating group will be used when the policy is issued to a participating group.

#### PAGE 6

OTHER INSURANCE: The maximum benefit payable may be other than the stated amount. This provision will be used when the company wants to limit coverage for individual insureds.

## **MASTER POLICY SLAD3700GP**

### **PAGE 1**

**COMPANY ADDRESS:** Stonebridge Life Insurance Company has several administrative office locations. This product may be solicited from one of three locations, depending on the market. The address on the forms will be one of the following:

- d) 2700 West Plano Parkway  
Plano, Texas 75075-8200
- e) 520 Park Avenue  
Baltimore, Maryland 21201
- f) Valley Forge, Pennsylvania 19493

Policy number, effective date and Policyholder name are specific to each policy.

The Right to Examine period may be 30, 60 or 90 days as determined by the policyholder.

### **PAGE 2**

#### **DEFINITIONS:**

**Participating Group** will be included when the policy is issued to a participating group.

**Aegon Affiliates** names the companies included in the affiliates and is used in conjunction with the Other Insurance provision.

### **PAGE 3**

#### **ELIGIBILITY:**

Defines the group and will vary based on the group the Policyholder is insuring.

**WHEN A PERSON BECOMES INSURED:** "before" or "within 21 days of" will be used depending on the issue system used.

### **PAGE 5**

**INFORMATION TO BE FURNISHED:** The term participating group will be used when the policy is issued to a participating group trust.

### **PAGE 6**

**PAYMENT OF PREMIUM:** the second paragraph and the beginning of the third paragraph will be used when the policyholder is paying the initial premium. The term participating group will be used when the policy is issued to a participating group.

### **Page 7**

**OTHER INSURANCE:** The maximum benefit payable may be other than the stated amount. This provision will be used when the company wants to limit coverage for individual insureds.

## ENROLLMENT FORM SLAD3700GE

Language will vary based on the offer by the policyholder who will choose whether spouse coverage is offered, options offered; customer information requested; beneficiary information requested. Below is an explanation of the bracketed portions of the form.

Variable Data	Explanation
[and my eligible spouse (if selected)]	used when the policyholder chooses to offer spouse coverage.
[Accidental Death]	variable so the enrollment can be used with different accident products.
[The coverage I want is:] [[01H <input type="checkbox"/> Coverage for me and my spouse at [\$xx.xx] per month.] [01G <input type="checkbox"/> Coverage for me only at [\$x.xx] per month].	Used when spouse coverage is offered and provides choice of benefits for insured and spouse
<input type="checkbox"/> Check here to [activate][select] coverage.....\$XXX,XXX]	Will be used when coverage is offered to the insured only
[I understand that if I send in my enrollment form and do not select an option above, I will be enrolled for coverage for me only.]	Will be used when benefit options for insured and spouse are offered by the policyholder
[XYZ Corporation accountholder or the spouse of an XYZ Corporation accountholder, age [18] through [74], with an account in good standing and reside in a state in which this product may legally be offered].	Eligibility language will change based on the policyholder name, description of the group and eligible ages
[The first month's coverage will be provided at no cost to me.]	Will be used when the policyholder chooses to pay for the initial premium
[I][a Covered Person] attain[s] age 80.	"I" is used when coverage is offered to the insured only; "covered person" is used when coverage is offered to the spouse as well.
[I have read the fraud notice on the back of this enrollment form as it applies to my state of residence.]	Used when the state specific fraud language is not used on the front of the enrollment form.  Fraud language will either be on the front of the enrollment for those states which require it or on the back of the enrollment form, depending on the marketing plan.

<p>[By signing below, I certify that I understand coverage is limited to the lesser of the total benefits payable for all Accidental Death Insurance with this Company, Stonebridge Casualty Insurance Company, Transamerica Life Insurance Company, Transamerica Financial Life Insurance Company and/or Monumental Life Insurance Company or [\$1,000,000].]</p>	<p>Discloses coverage limitations when the policyholder or company wants to limit total amount of coverage for a single insured who purchases Accidental Death Indemnity coverage.</p>
<p>Phone:(Home)[_____ _____]          [(Business)_____]</p>	<p>When marketing is targeting business owners, the business phone number will be requested.</p>
<p>[Beneficiary Designation: All benefits will be paid to you if living. Unless you specify below, any amount due for Loss of life will be paid in accordance with the Beneficiary Provision in your Certificate of Insurance.]</p>	<p>Used when the beneficiary language will reflect the provision in the certificate of coverage.</p>
<p>[Beneficiary to Be Paid At My Death: Beneficiary's Relationship to Me:</p>	<p>Used when the policyholder wants to provide an opportunity for the insured to designate a beneficiary at the time of enrollment.</p>
<p>C-82 CN-163</p>	<p>Coding used by Marketing and New Business to uniquely identify solicitations</p>
<p>CODE</p>	<p>Coding used by Marketing and New Business to uniquely identify solicitations</p>
<p>[2700 West Plano Parkway, Plano, Texas 75075-8200]</p>	<p>Address will be one of the 3 administrative offices described in the explanation for the certificate and policy.</p>